



**FY 2021 Health Center Program Service Expansion -  
School-Based Service Sites (SBSS)  
Application Forms Blank Sample**

**FORM 5B: SERVICE SITES**

OMB No.: 0915-0285. Expiration Date: 3/31/2023

<p align="center"><b>DEPARTMENT OF HEALTH AND HUMAN SERVICES</b> <b>Health Resources and Services Administration</b></p> <p align="center"><b>Form 5B: Service Sites</b></p>	<b>FOR HRSA USE ONLY</b>	
	Grant Number	Application Tracking Number
<p><b>Notes:</b></p> <ul style="list-style-type: none"> <li>You will use form 5B either to propose a new site or to select a current site from scope. If you are selecting a current site from scope, go to the previous page and click on "Pick from Scope".</li> <li>The addition of a service delivery site located at a school is required if you do not currently operate school-based service site(s) where you will implement your proposed SBSS project.</li> <li>Because SBSS funds are intended to increase access to school-based services in your existing service area, as of the NOFO release date, you may not expand your service area through this application. Note the following requirements: <ul style="list-style-type: none"> <li>Site Physical Address – The zip code of the Site Physical Address (where the school-based service site will be located or where a new mobile unit will be parked) must be included in your current service area, based on the Service Area Zip Codes listed across all current sites in scope (on Form 5B).</li> <li>Service Area Zip Codes – All Service Area Zip Codes listed for any proposed new site(s) must be included in your existing service area, based on the Service Area Zip Codes listed across all current sites in scope (on Form 5B).</li> </ul> </li> <li>Provide requested data, including a verifiable street address, for each proposed service site.</li> </ul>		

Fields with \* are required

<b>Site Qualification Criteria</b>	
<p>1. * Is the site an Admin-only site?</p> <p>If Yes, the site is an "Admin-only" site, select 'Not Applicable' for questions a through d below. If No, the site is a Service Delivery site, answer questions a through d Yes or No.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>a. Are/will health center visits be generated by documenting in the patients' records face-to-face contacts between patients and providers?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable
<p>b. Do/will providers exercise independent judgment in the provision of services to the patient?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable
<p>c. Are/will services be provided directly by or on behalf of the grantee, whose governing board retains control and authority over the provision of the services at the location?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable

d. Are/will services be provided on a regularly scheduled basis (e.g., daily, weekly, first Thursday of every month)?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	
2. * Is the site a Domestic Violence (Confidential) shelter?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	
<b>Site Information</b>			
* Site Name		* Physical Site Address	
* Site Type	<input type="checkbox"/> Administrative/Service Delivery Site <input type="checkbox"/> Service Delivery Site <input type="checkbox"/> Administrative Site	* Site Phone Number	
* Web URL			
<b>The following fields are required for “Service Delivery” and “Administrative/Service Delivery” site types:</b>			
*Location Type	<input type="checkbox"/> Permanent <input type="checkbox"/> Seasonal <input type="checkbox"/> Mobile <input type="checkbox"/> Migrant Voucher Screening <input type="checkbox"/> Intermittent	*Site Setting	<input type="checkbox"/> All Other Clinic Types <input type="checkbox"/> Hospital <input type="checkbox"/> School
Date Site was Added to Scope	<i>Read-only for sites already in scope and disabled when adding a new site</i>	*Site Operational Date	mm/dd/yyyy

<p>*FQHC Site Medicare Billing Number Status</p>	<p><input type="checkbox"/> This site has a Medicare billing number</p> <p><input type="checkbox"/> This site is neither permanent nor seasonal per CMS (i.e., does not require unique FQHC Medicare Billing Number)</p> <p><input type="checkbox"/> Health center does not/will not bill under the FQHC Medicare system at this site</p> <p><input type="checkbox"/> Number is pending; application for this site has been submitted to CMS</p> <p><input type="checkbox"/> Application for this site has not yet been submitted to CMS</p>	<p>FQHC Site Medicare Billing Number</p> <p>(Required if 'This site has a Medicare billing number' is selected in 'FQHC Site Medicare Billing Number Status' field)</p>	
<p>FQHC Site National Provider Identification (NPI) Number</p> <p>(Optional field)</p>		<p>* Total Hours of Operation (when patients will be served per week)</p>	
<p>Months of Operation</p>	<p>[Check All] [January] [February] [March] [April] [May] [June] [July] [August] [September] [October] [November] [December]</p>		
<p>Saved Months of Operation</p>	<p><i>prepopulated</i></p>		
<p>Number of Contract Service Delivery Locations</p> <p>(Required only for 'Migrant Voucher Screening' Site Type)</p>		<p>Number of Intermittent Sites (Required only for 'Intermittent Site' Type)</p>	
<p>* Site Operated by</p>	<p><input type="checkbox"/> Health Center/Applicant <input type="checkbox"/> Contractor <input type="checkbox"/> Subrecipient</p>		

Subrecipient or Contractor Information			
(Required only if 'Subrecipient' or 'Contractor' is selected in 'Site Operated By' field)			
Subrecipient/Contractor Organization Name	Subrecipient/Contractor Organization Physical Site Address	Subrecipient/Contractor EIN	Options
* Service Area Zip Codes	Enter up to five zip codes		
Saved Service Area Zip Code(s)	Prepopulated		

Public Burden Statement: Health centers (section 330 grant funded and Federally Qualified Health Center look-alikes) deliver comprehensive, high quality, cost-effective primary health care to patients regardless of their ability to pay. The Health Center Program application forms provide essential information to HRSA staff and objective review committee panels for application evaluation; funding recommendation and approval; designation; and monitoring. The OMB control number for this information collection is 0915-0285 and it is valid until 3/31/2023. This information collection is mandatory under the Health Center Program authorized by section 330 of the Public Health Service (PHS) Act ([42 U.S.C. 254b](#)). Public reporting burden for this collection of information is estimated to average 1 hour per response, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 14N136B, Rockville, Maryland, 20857 or [paperwork@hrsa.gov](mailto:paperwork@hrsa.gov).